movements of the child for two days. On examination the patient was evidently in the ninth month of gestation; the abdomen was greatly distended, so that a thorough examination was impossible. Neither heart sounds nor uterine souffle could be heard. The abdomen was very sensitive on pressure. The heart and lungs of the mother were practically normal, although the pulse and respiratory rate were increased. The tongue was heavily coated, and there was frequent vomiting of a greenish-yellow mucus. The patient's temperature was practically normal. The vomiting and abdominal distention increased, and the pulse rose to 140. Upon operation decomposed blood was found in the abdomen, the child had entirely escaped with its appendages through the uterus, the placenta lay upon the right side, the child with its back toward the left and posteriorly, the head near the left iliac bone. The uterus had firmly contracted and the scar of the former Cæsarean section had completely ruptured and a portion of the membranes remained within the rupture. The child was dead, the amniotic liquid a brownish-gray and discolored. The child and blood were removed from the abdomen and hysterectomy performed. The patient died shortly after the operation. Examination of the uterus showed that suture material had entirely disappeared from the scar. The placenta had been attached upon the anterior wall of the uterus and partially over the scar. Microscopic examination showed that the decidua extended over the entire laceration and upon the anterior wall. The uterus was remarkably firmly contracted.

The Cæsarean operation performed in the preceding pregnancy had been by the transverse incision at the fundus, silk had been used as suture material in the muscle, and catgut had been employed for peritoneal surfaces. This operation was performed about three years before the rupture of the uterus.

GYNECOLOGY.

UNDER THE CHARGE OF

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Lipoma of the Abdomen.—MICHEL (*Zentralblatt für Gynäkologie*, 1904, No. 41) reviews the literature of the subject thoroughly. He includes subcutaneous, intramuscular, pre- and retroperitoneal lipomata. The latter are of especial interest from a diagnostic standpoint, and are quite rare. The retroperitoneal variety is usually unilateral, developing either from the perirenal fat or between the peritoneal and abdominal wall in the iliac fossa, in the broad ligaments, or between the rectum and bladder. They may be sessile or pedunculated, single or multiple, and may reach an enormous size (twenty to sixty pounds). They are often so soft as to give the impression of fluctuation, hence

they have frequently been mistaken for ovarian cysts. They differ from the latter neoplasms in being less elastic and independent of the uterus, while the intestines lie in front of them or at one side, as in the case of renal growths. Peritoneal tuberculosis, cysts of the mesentery, and even the pregnant uterus may be confounded with lipomata.

The principal symptoms are those due to pressure on the hollow viscera and bloodvessels. The prognosis after operation for the removal of retroperitoneal lipomata is grave, only 4 recoveries having been reported out of 11 cases.

The pre-peritoneal variety develop between the peritoneum and transversalis fascia and grow into the abdominal cavity where they may become detached, so that it is difficult to distinguish them from hernia or fatty degeneration of the omentum. Through traction they may give rise to severe gastric symptoms. The writer reports an interesting case in which the diagnosis of ovarian cystoma was made. Various theories have been advanced regarding their origin, such as local disturbances of the circulation in the bloodvessels and lymphvessels, reflex nervous conditions, or aberrant cells (Recklinghausen). Local irritation, heredity and struma have also been stated to be etiological factors. A direct relation between thyroid hypertrophy and lipomata has been claimed by several observers. The writer inclines to Ribbert's theory of fetal inclusion. The only treatment is surgical, especially in view of the fact that sarcomatous degeneration has been noted in some instances.

Adnexal Disease Due to Typhoid Fever.—Dirmoser (*Zentralblatt für Gynäkologie*, No. 40, 1904) reports a case of tubo-ovarian abscess in a virgin who had typhoid six months before. The characteristic bacilli were found in the pus. A similar case was reported by Koch, who inferred that the infection came through the intestine. The writer believes that the bacilli make their way through the lymph channels in the gut to the surrounding connective tissue and thus reach the ovary and tube, though the possibility of hæmatogenous infection cannot be denied.

Patent Urachus.—Swirt (*Nederl. Tijdschrift v. Geneesk.; Zentralblatt für Gyn.*, 1904, No. 41) reports the following cases:

1. The patient, aged fifty-eight years, entered the hospital on account of retention of urine, while urine dribbled from the umbilicus. An artificial vesicovaginal fistula was established, when the urachus closed spontaneously, and later the fistula also.

2. A girl, aged seventeen years, had constant dribbling of urine from the navel, blood escaping from the same opening at every menstrual period. The edges of the fistula were split and a purse-string suture was inserted, followed by primary union.

3. A boy, aged one and one-half years, had eczema of the navel with a discharge of offensive urine; he had also a marked phimosis. Circumcision failed to cure the fistula. As there was diastasis of the recti muscles, the umbilicus was excised and the opening of the urachus was successfully closed with a purse-string suture.

Treatment after Curettement.—Oria (*Rev. de med. y cir, Madrid; Zentralblatt für Gyn.*, 1904, No. 41) believes that sufficient care is not